a. The Regional ACCESS Unit must determine that: (1-1-95)T

i. The recipient would qualify for ICF/MR level of care as set forth in Section 180 of these rules, if the waiver services listed in Section 143 of these rules were not made available; and (1-1-95)T

ii. The recipient could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the ISP team; and prior to any denial of services on this basis, be determined by the Service Coordinator that services to correct the concerns of the team are not available. (1-1-95)T

iii. The average daily cost of waiver services and other medical services to the recipient would not exceed the average daily cost to Medicaid of ICF/MR care and other medical costs. Individual recipients whose cost of services exceeds this average may be approved on a case by case basis that assures that the average per capita expenditures under the waiver do not exceed 100 percent of the average per capita expenditures for ICF/MR care under the State plan that would have been made in that fiscal year had the waiver not been granted. This approval will be made by a team identified by the Administrators of the Divisions of Welfare and Family and Community Services. (1-1-95)T

iv. Following the approval by the ACCESS Unit for services under the waiver, the recipient must receive and continue to receive a waiver service as described in these rules. A recipient who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (1-1-95)T

b. A recipient who is determined by the ACCESS Unit to be eligible for services under the Home and Community Based Services Waiver for developmentally disabled may elect to not utilize waiver services but may choose admission to an ICF/MR. (1-1-95)T

c. The recipient's eligibility examiner will process the application in accordance with Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, except that the eligibility examiner will forward potentially eligible applications immediately to the ACCESS Unit for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (1-1-95)T

d. The decisions of the ACCESS Unit regarding the acceptance of the recipients into the waiver program will be transmitted to the eligibility examiner. (1-1-95)T

08. Case Redetermination. (1-1-95)T

a. Financial redetermination will be conducted pursuant to Idaho Department of Health and Welfare Rules, Title 3, Chapter 1, "Rules Governing Eligibility for Aid to Families with Dependent Children (AFDC)," and Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the ACCESS Unit, or sooner at the request of the recipient, the eligibility examiner, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions. (1-1-95)T

b. The redetermination process will assess the following factors: (1-1-95)T

i. The recipient's continued need for waiver services; and (1-1-95)T

ii. Discharge from the waiver services program; and (1-1-95)T

09. Provider Reimbursement. (1-1-95)T

a. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (1-1-95)T

b. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (1-1-95)T

c. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the recipient's home or other service delivery location when the recipient is not being provided transportation. (1-1-95)T

10. Client Participation. A recipient will not be required to participate in the cost of waiver services unless his entitlement to MA is based on his approval for and receipt of a waiver service and income limitations contained in Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, Section 634, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Income excluded under the provisions of Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, Sections 613 and 615, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," is excluded in determining client participation. (1-1-95)T

a. The following definitions apply to determining client participation: (1-1-95)T

i. Community Spouse is defined as the spouse of an HCBS recipient who is not an HCBS client and is not institutionalized. (1-1-95)T

ii. Community Spouse Allowance (CSA) is the maximum amount deducted from a recipient's income for support of his community spouse. (1-1-95)T

iii. Community Spouse Need Standard (CSNS) is the total income the community spouse needs for his support. This amount must not exceed one thousand eight hundred and sixteen dollars and fifty cents. ($1,816.50). (1-1-95)T

b. For individuals with no community spouse, the amount of client participation for an individual who is not exempt from the client participation requirement and who has no community spouse is determined by deducting certain amounts from the client's income, after the AABD income exclusions are deducted. A veteran with no spouse or other dependents or the surviving spouse of a veteran with no dependents, receives a protected VA pension, which amount will not be counted as income for client participation. This protected amount is ninety dollars ($90). The following amounts are deducted in the following order from the individual's own income, including income disregarded in determining his MA eligibility: (1-1-95)T

i. First, determine the individual's standard of need. The standard of need is three (3) times the federal SSI benefit amount to an individual in his own home; and (1-1-95)T

ii. Second, an employed client or client engaged in sheltered workshop or work activity center activities, is also budgeted the lower of an additional personal needs deduction of eighty dollars ($80) or his earned income. The client's total personal needs allowance must not exceed the sum of his AABD standard of need plus up to eighty dollars ($80). This is a deduction only. No actual payment can be made to provide for personal needs. (1-1-95)T

iii. Third, a Family Member Allowance (FMA) for each person who is, or could be claimed on the client's federal income tax and who is the client's minor or dependent child, dependent sibling, or dependent parent who lives in the client's home. The FMA is computed by deducting the family member's gross income from one thousand two hundred and thirty dollars ($1,230) and dividing the result by three (3). Any remainder with cents is rounded to the next higher dollar and is the FMA for that family member; and the family member's gross income is used; the FMA is deducted from the client's income whether or not it is actually contributed by the client; if the client contributes an amount less than the FMA, only the actual amount contributed is deducted. If more, only the FMA is deducted. (1-1-95)T

iv. Fourth, amounts for the individual's incurred expenses for Medicare and other health insurance premiums, deductibles or coinsurance charges not paid by a third party. Deduction of incurred expenses for the Medicare Part B premium is limited to the first two (2) months of Medicaid eligibility. If the individual received SSI or an AABD payment for the month prior to the month for which client participation is being calculated, Medicare Part B premiums must not be deducted. The client must report such expenses to the field office and provide verification in order for an expense to be considered for deduction. (1-1-95)T

v. Fifth, amounts incurred for certain limited medical or remedial services not covered by the State's Medicaid Plan and not paid by a third party. The Department must determine whether an individual's incurred expenses for such limited services meet the criteria for deduction. The client must report such expenses to the ACCESS Unit and provide verification in order for an expense to be considered for deduction. Deductions for necessary medical or remedial expenses approved by the Department will be applied at the time of application, and as necessary, based on changes reported to the field office by the recipient. (1-1-95)T

c. For individuals with community spouse, after income of the HCBS spouse and the community spouse has been attributed according to the provisions of Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, Section 615, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)", the amount of client participation for an individual who is not exempt from the participation requirement is determined. Income excluded under AABD is not counted. Income disregarded under AABD is not counted. Deduct the following amounts in the following order from the income attributed to the recipient. (1-1-95)T

i. First, a personal need allowance of thirty dollars ($30). A client who is unable to live with his community spouse because of his medical condition or other similar circumstances beyond his control is allowed a personal needs allowance equal to the AABD payment standard he would be budgeted for his living situation, if he was a AABD client. An employed client or client engaged in sheltered workshop or work activity center activities is also allowed the lower of eighty dollars ($80) or his earned income, for his personal needs. The total personal needs allowance must not exceed one hundred ten dollars ($110); and (1-1-95)T

ii. Second, the Community Spouse Allowance (CSA) is determined by: computing the Shelter Adjustment by subtracting three hundred and sixty-nine ($369) dollars from the sum of total shelter costs (rent, mortgage principle and interest, homeowner's taxes, insurance, condominium or cooperative maintenance charges) and the Standard Utility Allowance of one hundred and sixty-two dollars ($162). The Standard Utility Allowance is reduced by the value of any utilities which are included in maintenance charges for a condominium or cooperative. The Shelter Adjustment equals the positive balance remaining from the calculation in Subsection 143.11.c.ii.(1); computing the Community Spouse Needs (CSN) by adding one thousand two hundred and thirty ($1,230) dollars to the Shelter Adjustment. The total CSNS must not exceed the maximum of one thousand eight hundred and sixteen dollars and fifty cents ($1,816.50). If a hearing or court order establishes the community spouse needs a larger amount

of income than established above, such amount will not be subject to the maximum; computing the Community Spouse Allowance (CSA) by subtracting the community spouse's gross income from the CSNS and rounding any remaining cents to the next higher dollar. Any positive balance remaining is the CSA except if a court orders the institutional spouse to contribute a larger amount for the support of the community spouse, then the amount of support ordered by the court will be used instead of the CSA. Any amount ordered by the court will not be subject to the limit on the CSNS. The CSA will only be deducted to the extent contributed by the institutional spouse. If the institutional spouse contributes an amount less than the CSA, only the actual amount contributed will be deducted from the institutional spouse's gross income. (1-1-95)T

iii. Third, a Family Member Allowance (FMA) for each family member. A family member is a person who is, or could be claimed as a dependent on either a spouse's federal income tax and who is a minor or dependent child, dependent sibling or dependent parent of either spouse who lives in the community spouse's home. The FMA is computed by deducting the family member's gross income from one thousand two hundred thirty ($1,230) dollars and dividing the result by three (3). Any remainder with cents rounded to the next higher dollar is the FMA for that family member; and the family member's gross income is used; the FMA is deducted from the institutional spouse's income whether or not it is actually contributed by the institutional spouse; if the institutional spouse contributes an amount less that the FMA, only the actual amount contributed is deducted from the institutional spouse's gross income. If more, only the FMA is deducted. (1-1-95)T

iv. Fourth, the amounts for incurred expenses for Medicare and other health insurance premiums, deductibles or coinsurance charges not subject to payment by a third party. Deduction of incurred expenses for the Medicare Part B premium is limited to the first two (2) months of Medicaid eligibility. If the individual received SSI or an AABD payment for the month client participation is being calculated, Medicare Part B premiums must not be deducted. The client must report such expenses to the field office and provide verification in order for an expense to be considered for deduction. (1-1-95)T

v. Fifth, amounts incurred for certain limited medical or remedial services not covered by the State Medicaid Plan and not paid by a third party. The Department's Regional ACCESS Units must determine whether an individual's incurred expenses for such limited services meet the criteria for deduction. The client must report such expenses to the ACCESS Unit and provide verification in order for an expense to be considered for deduction. Deductions for necessary medical or remedial expenses by the Department will be applied at the time of application, and as necessary, based on changes reported to the field office by the recipient. (1-1-95)T

d. Any remainder after the calculation in subsection 143.11.b. or c. is to be deducted from the recipient's provider payments to offset the cost of waiver services. The contribution will be collected from the recipient by the provider agency or independent provider. The provider and the recipient will be notified of the amount to be collected. (1-1-95)T

e. The client participation amount is to be recalculated annually at redetermination or whenever a change in income or deductions is reported to the ACCESS Unit by the recipient. (1-1-95)T

11. Provider Records. Three types of record information will be maintained on all recipients receiving waiver services: (1-1-95)T

a. Direct Service Provider Information which includes written documentation of each visit made or service provided to the recipient, and will record at a minimum the following information: (1-1-95)T

i. Date and time of visit; and (1-1-95)T

ii. Services provided during the visit; and (1-1-95)T

iii. A statement of the recipient's response to the service, if appropriate to the service provided, including any changes in the recipient's condition; and (1-1-95)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the recipient is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the recipient as evidenced by their signature on the service record. (1-1-95)T

v. A copy of the above information will be maintained in the recipients home unless authorized to be kept elsewhere by the ACCESS Unit. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (1-1-95)T

b. The individual support plan which is initiated by the ACCESS Unit and developed by the Service Coordinator and the ISP team must specify which waiver services are required by the recipient. The plan will contain all elements required by Subsection 143.03. and a copy of the most current individual support plan will be maintained in the recipient's home and will be available to all service providers and the Department. (1-1-95)T

c. In addition to the individual support plan, at least monthly the service coordinator will verify in writing, that the services provided were consistent with the individual support plan. Any changes in the plan will be documented and include the signature of the service coordinator and when possible, the recipient. (1-1-95)T

12. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator when any significant changes in the recipient's condition are noted during service delivery. Such notification will be documented in the service record. (1-1-95)T

13. Records Maintenance. In order to provide continuity of services, when a recipient is transferred among service providers, or when a recipient changes service coordinators, all of the foregoing recipient records will be delivered to and held by the Regional ACCESS Unit until a replacement service provider or service coordinator assumes the case. When a recipient leaves the waiver services program, the records will be retained by the Regional ACCESS Unit as part of the recipients closed case record. Provider agencies will be responsible to retain their client's records for three (3) years following the date of service. (1-1-95)T

14. Home and Community-Based Waiver Recipient Limitations. The number of Medicaid recipients to receive waiver services under the home and community based waiver for developmentally disabled recipients will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30, of each new waiver year. The earliest effective date of waiver service delivery for these recipients will be October 1 of each new waiver year. (1-1-95)T

144. FEDERALLY QUALIFIED HEALTH CENTER (FQHC). Federally qualified health centers are defined as community health centers, migrant health centers or providers of care for the homeless, as well as clinics that qualify but are not actually receiving grant funds according to Section 329, 330 or 340 of the Public Health Service Act that may provide ambulatory services to MA recipients. (4-1-90)

01. Care and Services Provided. FQHC services are defined as follows: (4-1-90)

a. Physician services; or (4-1-90)

b. Services and supplies incidental to physician services including drugs and pharmaceuticals which cannot be self-administered; or (4-1-90)

c. Physician assistant services; or (4-1-90)

d. Nurse practitioner services; or (4-1-90)

e. Clinical psychologist services; or (4-1-90)

f. Clinical social worker services; or (4-1-90)

g. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist or clinical social worker services which would otherwise be covered if furnished by or incident to physician services; or (4-1-90)

h. In the case of an FQHC that is located in an area that has a shortage of home health agencies, FQHC services are part-time or intermittent nursing care and related medical services to a home bound individual; and (4-1-90)

i. Other payable Title XIX payable ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide; and (4-1-90)

j. Pneumococcal or immunization vaccine and its administration. (4-1-90)

02. Encounter. An encounter is a face-to-face contact for the provision of medical services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist or other specialized nurse practitioner specified in Subsections 144.01.a. through 144.01.h. (12-31-91)

a. Contact with more than one (1) health professional or multiple contacts with the same professional in the same day and in the same location constitutes a single encounter unless the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment; (4-1-90)

i. A core service ordered by a physician who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter; (4-1-90)

ii. Multiple contacts with clinic staff of another discipline defined in Subsections 144.01.a. through 144.01.h. considered a single encounter; (12-31-91)

b. Other ambulatory services, not counted as an encounter or reimbursed under an encounter rate, which a FQHC may use its employees or may subcontract, includes radiology, physical therapy, occupational therapy, speech therapy, audiology services, dental services, pharmacy services, independent laboratory services, physician specialists, optometry, nutritional education or dietary counseling and monitoring by a registered dietician, ambulance and other medical services which are rendered safely, efficiently and effectively. (4-1-90)

03. Conditions of Participation. A qualified FQHC may be recognized as a Medicaid provider as of April 1, 1990, with the following stipulations: (7-1-94)

a. The provider is confirmed eligible by the Public Health Service on and after April 1, 1990; and (4-1-90)

b. The applicant's request for a retroactive provider agreement may be approved from: (4-1-90)

i. The date on which it was granted FQHC eligibility by the Public Health Service; or (4-1-90)

ii. Retroactively for dates of service on or after April 1, 1990, for Medicaid provider agreements executed by October 31, 1991; or (4-1-90)

iii. As otherwise specified in the provider agreement for applications received after October 31, 1991. (4-1-90)

c. The FQHC applicant shall simultaneously terminate its Medicaid rural health clinic and other Department specified Medicaid agreements from which the FQHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement; and (4-1-90)

d. Written agreements between the provider and subcontractors shall state that the subcontractor shall retain related records for at least three (3) years after each provider's fiscal year end. The written agreements shall assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services or their respective designee. The agreement shall specify that failure to maintain such records voids the agreement between the subcontractor and the provider. (4-1-90)

145. RURAL HEALTH CLINICS. (12-31-91)

01. Care and Services Provided. The following items of care and services will be available to MA recipients: (11-10-81)

a. Services furnished by a physician within the scope of practice of the medical profession under state law; and (11-10-81)

b. Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner, a clinical psychologist or by a clinical social worker within the scope of practice of his profession under state law; and (4-1-90)

c. Supplies that are furnished incidental to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner clinical psychologist or a clinical social worker; and (4-1-90)

d. Part-time or intermittent visiting nurse care and related medical supplies will be provided to homebound recipients in a home health agency shortage area; and (11-10-81)

e. Other ambulatory services furnished by a rural health clinic. (11-10-81)

02. Payment Rates.

a. Payment for rural health clinic services must not exceed the cost rate basis as established by the Medicare contractor. (11-10-81)

b. Payment for ambulatory services must be at the rates established by the Department but must not exceed Medicare rates. (11-10-81)

146. PERSONAL CARE SERVICES. Pursuant to Sections 39-5601 through 39-5607, Idaho Code, it is the intention of the Department to provide personal care services to eligible recipients in their personal residence in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to maintain community integration. For a recipient to be eligible for personal care services, the Department must find that the recipient requires personal care services due to a medical condition which impairs their physical or mental function or independence and must find the recipient

capable of being maintained safely and effectively in their own home or residence with personal care services. (1-1-91)

01. Care and Services Provided. (1-1-91)

a. Medically oriented tasks having to do with a patient's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the patient's home. Such services may include, but are not limited to: (1-1-91)

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care, but excluding the irrigation or suctioning of any body cavities which require sterile procedures and the application of dressings, involving prescription, medication, and aseptic techniques; and (1-1-91)

ii. Assistance with bladder or bowel requirements which may include helping the patient to and from the bathroom or assisting the patient with bedpan routines, but excluding insertion or sterile irrigation of catheters; and (5-1-87)

iii. Assisting the patient with medications which are ordinarily self-administered, when ordered by a physician, but excluding the giving of injections or fluids into the veins, muscles, or skin, or administering of medicine; and (7-15-83)

iv. Assistance with food, nutrition, and diet activities to include the preparation of meals if incidental to medical need, as determined by a physician; and (7-15-83)

v. The continuation of active treatment training programs in the home setting to increase or maintain client independence for the developmentally disabled client. (5-1-87)

vi. Non-nasogastric gastrostomy tube feedings may be performed if authorized prior to implementation by the Department's Regional Medicaid Unit and if the following requirements are met: (2-19-92)

(a) The task is non-complex and can be safely performed in the given patient care situation; and (2-19-92)

(b) A registered nurse has assessed the patient's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, which is individualized for the patient's characteristics and needs; and (2-19-92)

(c) Persons to whom the procedure can be delegated are identified by name. The registered nurse must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing strengths and weaknesses of the person performing the procedure, and evaluate the performance of the procedure at least monthly; and (2-19-92)

(d) Any change in the patient's status or problem relative to the procedure must be reported immediately to the registered nurse; and (2-19-92)

(e) The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN, and must be readily available for review, preferably with the patient's record. (2-19-92)

(f) Medication previously received could be given by the personal care provider through the non-nasogastric tube unless contraindicated. (2-19-92)

vii. In addition to performing at least one (1) of the services listed in Subsections 146.01.a.i. through 146.01.a.vi., the provider may also perform the following services: (2-19-92)

(a) Such incidental housekeeping services essential to a patient's comfort and health, to include the changing of bed linens, rearranging furniture to enable the patient to move about more easily, laundry and room cleaning when incidental to the patient's treatment. Excluded are cleaning and laundry for any other occupant of the patient's residence; and (2-19-92)

(b) Accompanying the patient to clinics, physician office visits, or other trips which are reasonable for the purpose of obtaining medical diagnosis or treatment; and (7-15-83)

(c) Shopping for groceries or other household items required specifically for the health and maintenance of the patient. (2-19-92)

b. Service Limitations. The maximum amount of personal care services available to an eligible recipient is dependent on whether services are obtained under the Home and Community-based Services waiver (HCBS waiver) or under the State Medicaid Plan Service option. (1-1-91)

i. For adults receiving services under the State Medicaid Plan option, service delivery is limited to a maximum of sixteen (16) hours per week per recipient. (10-1-94)T

ii. For individuals under the age of twenty-one (21) who meet medical necessity criteria under EPSDT, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery under the State Plan option. (10-1-94)T

iii. For individuals receiving services under the HCBS waiver, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery, based on the medical need for such service as documented in the plan of care and the cost effectiveness criteria under the waiver program. (1-30-94)

02. Place of Service Delivery. Personal Care Services (PCS) may be provided only in a recipient's personal residence. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (1-1-91)

a. Certified nursing facilities (NF) or hospitals; and (1-1-91)

b. Licensed Intermediate Care Facility for the Mentally Retarded; and (7-15-83)

c. Licensed Residential Care Facility. (1-1-91)

d. Licensed child foster care Level III professional child's foster homes and adult foster homes. (1-1-91)

03. Services Delivered Following a Written Plan. (7-15-83)

a. All PCS are provided based on a written plan of care which is the responsibility of the supervisory nurse to prepare and is based on: (7-15-83)

i. The physician's information including the physician's orders; and (7-15-83)

ii. The nurse's assessment and observations of the patient; and (7-15-83)

iii. Information elicited from the recipient. (7-15-83)

b. The plan of care must include all aspects of personal care necessary to be performed by the PCS provider, including the amount, type, and frequency of such services. (7-15-83)

c. The plan of care will be signed and approved by the physician prior to the initiation of the services by the PCS provider. (7-15-83)

d. The plan must be revised and updated based upon treatment results or a patient's changing profile of needs as necessary, but at least annually. (7-15-83)

04. Physician Supervision of the Service. All Personal Care Services are provided under the order of a licensed physician. The physician must: (1-1-91)

a. Provide such medical information to the Department's Regional Medicaid Unit (RMU) as is necessary to establish that the recipient is medically eligible for NF or ICF/MR placement for those recipients receiving PCS under the Department's Home and Community Based Services waivers. For recipients eligible for PCS under the Idaho State Plan, the physician will certify, in writing, that the services are medically necessary. (7-1-94)

b. Order all services delivered by the PCS provider. Such orders are signed and dated by the physician and include, at a minimum, his signature and date of approval on the recipient's plan of care. (7-15-83)

c. Update the plan of care, including his signature and date of approval, as necessary, but at least annually. (1-1-91)

d. Recommend institutional placement of the recipient if he identifies that P.CS, in combination with other community resources, are no longer sufficient to ensure the health or safety of the recipient. (1-1-91)

05. Service Supervision. (1-1-91)

a. A registered nurse who is not functioning as the personal care provider will oversee the delivery of PCS Such oversight will include: (1-1-91)

i. In conjunction with the attending physician the development of a plan of care for the recipient; and (1-1-91)

ii. Review of the treatment given by the personal care provider through a review of the recipient's PCS record as maintained by the provider and on-site interviews with the patient at least every ninety (90) days; and (1-1-91)

iii. Reevaluate the plan of care as necessary and obtaining physician approval on all changes. The entire plan is reviewed at least annually; and (1-1-91)

iv. Immediately notifies the physician of any significant changes in the recipient's physical condition or response to the service delivery; and (1-1-91)

v. Provides an on-site visit to the recipient to evaluate changes of condition when requested by the PCS provider, QMRP supervisor, provider agency, case manager, or recipient. (1-1-91)

b. In addition to the supervisory visit by the registered nurse, all clients who are developmentally disabled, other than those with only a physical disability, as determined by the Regional Medicaid Unit will receive oversight of service delivery by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430. Such oversight will include: (8-5-91)